STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185182	A. BUILDING _____ B. WING _____	09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE COMMUNITY HOSPITAL	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on September 14-16, 2010. Deficient practice was cited with the highest scope and severity at "F" level.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Carlton Bonch | Admr | 11/1/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to inform the physician regarding a change in condition for one (1) of eleven (11) sampled residents. A review of progress notes revealed on September 15, 2010, Occupational Therapy (OT) and Speech Therapy (ST) made recommendations for resident #8 to be seen for therapy services. In addition, the ST recommended the resident's diet be changed from thin liquids to nectar-thickened liquids. However, there was no evidence the facility staff informed the resident's physician of these recommendations for resident #8 until September 16, 2010. The findings include: 1. A review of the medical record revealed resident #8 was admitted to the facility on September 14, 2010, with a diagnosis of CVA with Dysphagia. Record review revealed resident #8's diet upon admission was puree with thin liquids and aspiration precautions were to be used when resident #8 had any type of oral intake. Further review of resident #8's progress notes dated September 15, 2010, revealed the occupational therapist had assessed resident #8. According to the progress note/physician order form, the OT requested treatment orders for three times a week for twelve weeks to focus on activities of daily living retraining, neuromuscular re-education, cognitive re-education, patient/staff education, safety, adaptive equipment needs, functional transfers/mobility, therapeutic	F 157	F157 Physician of resident #8 was notified of recommendations per MDS Coordinator on 9/16/10 @ 2:30 PM to obtain orders for the recommendations. On 9/16/10 @ 2:16 PM an order was sent to the Dietary Department to change the resident's diet to Nectar thickened liquids with supper meal. A review of all residents and their records were conducted on 9/20-9/21/10 to ensure that no orders for therapy or other treatments had been written and not acted upon. There were no other residents with orders that had not been acknowledged. The Medical Staff, at the regularly scheduled Medical Staff meeting of 9/21/10 discussed and approved for the ancillary therapies of Speech Therapy and Occupational Therapy to be able to write orders for treatment modalities assessed as being necessary for Nursing Facility residents. These ancillary departments, upon completion of evaluation, will write orders within the specific disciplines scope of practice to initiate the recommended treatment modalities. (See attached Minutes of Medical Staff Committee Minutes of 9/21/10.) Inservice education on the new procedure was conducted for Licensed Nurses and OT/ST/PT on 9/29/10 by the Chief Nursing Officer.	9/29/10

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F 157	Continued From page 2 exercise/activities, and activity tolerance. In addition, a ST consultation had been conducted on September 15, 2010, due to a diagnosis of aphasia, apraxia, and dysphagia. The ST requested resident #8 be seen for speech therapy treatment three times a week for four weeks for services to offer oral trials and monitor swallowing for potential diet upgrades. The ST recommended resident #8 continue on a puree diet; however, the ST recommended nectar-thickened liquids. Observation of resident #8 on September 16, 2010, at 1:15 p.m., revealed a lunch tray had been delivered and set up for resident #8. Observation of this meal revealed the resident was served a puree diet with thin liquids. Interview with resident #8's son on September 16, 2010, at 1:15 p.m., revealed the resident had been fed a puree diet and had drunk regular liquids with her meal. These liquids included whole milk and water. Interview with the ST on September 16, 2010, at 1:45 p.m., revealed the speech therapist had made progress notes and a request for resident #8's diet to be changed from thin liquids to nectar-thickened liquids on September 15, 2010. Interview revealed the speech therapist had informed a nurse on the floor regarding the request for the diet order change and therapy treatment orders to be implemented. The ST was unaware the nurse had not contacted resident #8's physician to ensure orders had been obtained. The ST was unable to recall the name of the nurse he/she had informed of these requests made on September 15, 2010.	F 157	F 157 Continued The policy/procedure for Transcription of Physician Orders was revised to reflect changes for the therapies of OT/ST to be able to write orders for recommendations and assist with physician notification. Nursing Staff were inserviced 9/29/10 on the policy change. (See attached policy/procedure and Inservice Attendance Record.) The policy/procedure for Notification of Changes was revised to include a new form of trreatment as being "significant" and requiring immediate notification to the physician. All staff were inserviced on the policy revisions on 10/8-10/12/10. Nursing and OT/ST/PT received inservice on the need to notify the physician immediately when treatment orders are written. A Performance Improvement monitor has been developed to assess for compliance with policy on Notification of Changes. Medical record review and actual observation will be conducted by the Facility DON on 10 residents per month to assess for compliance. Results of findings will be reported monthly to the Chief Nursing Officer for reporting quarterly at the Nursing Facility Committee Meetings.	

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F 157	Continued From page 3 Review of the Medication Administration Policy/Procedure revealed the facility required only licensed personnel to accept verbal or telephone orders from a physician. The policy also stated the nurse accepting a verbal/telephone order was to write the order down and repeat the order back to the physician and write (read back and verified order) by the nurse's signature and title. Interview with the Director of Nursing (DON) on September 16, 2010, at 1:50 p.m., revealed the speech therapist and the occupational therapist were required to inform the nurse of their recommendations. The DON stated the nurse was responsible for calling the physician and getting orders for the treatment visits and any changes made in the resident's diet. The Director of Nursing stated the therapists were not allowed to call a physician and get any type of orders. The DON stated if the nurse was informed by the therapist, then the physician should have been notified and orders received if deemed necessary by the physician.	F 157	F157 Continued An indicator to assess for compliance with timely orders after evaluation by Speech Therapy and Occupational Therapy was added to the Nursing Documentation Audit for the Nursing Facility. A review of each resident's record will be conducted monthly by the Nursing Facility Director of Nursing to ensure that orders for therapy recommendations have been initiated timely. Results of findings will be reported quarterly to the Nursing Facility Committee by the Nursing Facility DON. (See attached Nursing Documentation Audit tool and reporting calendar.) The respective therapy discipline, with the assistance of the Licensed Nurses, will be responsible for communication of the treatment plan and orders for the resident to the resident's attending physician immediately upon the initiation of therapy with the verbal/telephone orders to be authenticated within 48 hours per policy. The therapists/licensed nurse will obtain the physicians signature on the order as evidence of approval of treatment. Compliance will be monitored via the Nursing Facility DON on a concurrent basis. 30 residents will be reviewed quarterly. Results of findings will be reported quarterly to the Nursing Facility Committee by the DON. (See attached Nursing Documentation Audit Tool and Reporting Calendar.)	
F 164 SS=B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this	F 164		

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F 164	Continued From page 4 section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of the policy/procedure, the facility failed to protect the resident's privileged medical information for one (1) resident (resident #12) during the medication observation pass conducted on September 14, 2010. During the medication observation pass, the Medication Administration Record (MAR) was left visible on the computer screen located in the hallway exposing the resident's medical information to the public. The findings include: A medication observation pass conducted for resident #12 on September 14, 2010, at 10:30 a.m., revealed the facility staff nurse (LPN #1) prepared the resident's medication by viewing the resident's MAR via a computer screen. The LPN was observed to transport the resident's	F 164	F164 Another nurse came along and signed the nurse off so that resident #12's MAR would not be visible. Inservice education was provided to employees on confidentiality of resident information via computers with recommendations to minimize screen or pivot screen out of public eyesight before leaving the medication care computer or workstation on wheels unattended. The CPSI policy for "Sign off Procedure" was revised to require the employees sign off on a mobile care station prior to leaving it unattended. Inservice was provided to all staff on the revisions to the policy. (See attached policy/procedure and Inservice Attendance Record.)	10/12/10

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F 164	Continued From page 5 medication to the resident's room located several feet from the computer. When the LPN walked away from the computer the resident's medical information, which included the resident's name and prescribed medications, was still visible on the computer screen. Other facility staff was observed to be in the hallway while the resident information was exposed. After LPN #1 had administered the medications to resident #12 and approached the computer, another LPN (LPN #2) informed LPN #1 that the computer screen had been left on and LPN #2 had turned off the computer screen. An interview conducted with LPN #1 on September 16, 2010, at 9:35 a.m., revealed the LPN was required to sign off the computer before leaving the computer unattended to administer the resident's medications. LPN #1 stated this would block the information from being viewed. A review of the facility policy/procedure regarding Administration of Medication (no date) revealed privacy was to be maintained during medication administration.	F 164	F164 Continued A performance improvement indicator has been added to the Nursing Facility Nursing Documentation Audit to monitor for compliance with confidentiality of computerized resident medical records. A sample size of 30 residents will be monitored via direct observation by the Nursing Facility Director of Nursing quarterly. Results of findings will be reported to the Nursing Facility Committee by the Chief Nursing Officer on a quarterly basis. F167 The Executive Secretary to the Chief Nursing Officer took a copy of the most recent survey results to the facility and placed it in the Survey Results book on 9/14/10 during the survey.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167	A Performance Improvement indicator has been added to the Nursing Documentation Audit for Nursing Facility to monitor monthly for the presence of the most recent survey results being present in the book on the unit. The Director of Nursing for the Nursing Facility will directly observe for the presence of the survey results on random days once a month. Results of findings will be reported quarterly to the Nursing Facility committee by the Nursing Facility Director of Nursing. (See attached Nursing Documentation Audit Tool.)	9/20/10

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F 167	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide residents/visitors with the right to examine the results of the most recent survey conducted by the state survey agency. Observations on September 14, 2010, revealed the survey results were not readily accessible for facility residents/visitors. The findings include: Observation upon entrance to the facility on September 14, 2010, revealed a sign which identified that survey results were available for review. Observation of the notebook labeled "Survey Report" revealed the most recent survey results were not in the notebook and not accessible for review. An interview with the Director of Nursing (DON) conducted on September 14, 2010, at 1:50 p.m., revealed the survey report should have been in the notebook and the DON was unaware the survey report was not available. The DON stated, "I am sure we put them in there, I have no idea what could have happened to them."	F 167	F 167 continued On 10/5/10 @ 11:50 AM the Chief Nursing Officer conducted a walk thru and checked the Survey report book on the unit. The most recent survey results were posted in the book.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225		

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F 225	Continued From page 7 court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure all allegations involving misappropriation of resident property were investigated and reported to the appropriate state agencies for two (2) of eleven (11) sampled residents (residents #1 and #4) . The findings include:	F 225		

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F 225	Continued From page 8 During a resident group meeting conducted on September 14, 2010, at 3:00 p.m., residents #1 and #4 verbalized concerns related to missing personal items. These residents stated when missing items were reported to facility staff nothing was done. These residents further stated the facility staff did not always replace missing items nor did the facility always inform the residents of the outcome of the report. 1. Resident #1 stated that the resident had reported to facility staff that $30.00 and a bottle of Paul Mitchell hairspray was missing. Resident #1 stated that several employees had been informed but nothing had been done. 2. Resident #4 stated that two bottles of shampoo had been missing. Resident #4 stated that someone found the shampoo and the next day it was missing again. After informing staff, nothing was done when the shampoo was missing the second time. A review of the facility's abuse policy/procedure (dated December 2002) revealed that misappropriation of personal property was defined as "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money without the resident's consent." The policy/procedure required that the supervisor or designee investigate any report of a loss or theft of a resident's property. The supervisor was responsible for getting back to the resident, his/her family, or staff with a response to any complaint. According to the policy, the supervisor was required to report any such concern to the Risk Manager and Department Director.	F 225	F 225 Resident #1 missing items was reported to the Chief Nursing Officer on 9/15/10. Appropriate notification was made to the facility Risk Manager, CEO, APS, OIG, and the residents attending physician. Follow up reporting was accomplished on 9/20/10 and the allegation could not be substantiated. After internal investigation with what information was available. The CNO had not been made aware of Resident' #4's allegation to conduct appropriate investigation. The CNO discussed Resident #4's allegation with facility staff and the activities coordinator. No one had any knowledge of the resident reporting the second occurrence of the shampoo missing. The Activities Coordinator had knowledge of the first incident but had failed to report to the CNO. The Unit Supervisor instructed the resident to immediately report any instances of personal property missing to a staff member. A sign has been posted in each resident's room and each resident/family member has been instructed to report immediately the loss of any personal items to a staff member. (See attached signage that has been posted in each resident's room and throughout the facility.)	10/5/10

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F 225	Continued From page 9 Further review of the facility's abuse policy/procedure revealed the policy did not include that all reports of misappropriation of resident property be reported by the Facility Administrator or designee to the appropriate state agencies (Department for Community Based Services, Adult Protective Services, and Office of Inspector General) immediately as required by state law. The policy/procedure required that an investigation would be conducted and written interviews and other pertinent information would be documented. The policy/procedure further required that the resident and/or responsible party be notified of the outcome of the investigation and the disposition of the reported findings. An interview conducted with the facility DON on September 15, 2010, at 11:25 a.m., revealed when residents reported that personal property was missing the facility "looked for" the resident's missing items. The DON stated the Supervisor was responsible to report the incident to the DON and the Risk Manager. However, no one had reported that resident #1 had missing hairspray or that resident #4 had missing shampoo. The DON stated the facility had investigated the missing $30.00 reported by resident #1. The DON stated the facility was not aware of a timeframe regarding the investigation of missing items or the need to report to the appropriate agencies. The DON revealed the facility considered that misappropriation of personal property only referred to monies and not personal items such as shampoo and hairspray.	F 225	F 225 Continued Inservice education provided to employees in all departments on misappropriation of property and procedure to report immediately so that appropriate reporting requirements and investigative processes can be accomplished. The Facility Director of Nursing will be conducting a weekly survey of all residents and inquiring as to whether the resident has any personal property missing. Any reports of misappropriation of resident property will be addressed per policy. The policy/procedure for Abuse, Neglect and Misappropriation of resident property has been revised to more clearly define the procedure for reporting the loss of a resident's personal property to the appropriate individuals/agencies. A tracking form has been developed to be used by the Chief Nursing Officer in tracking all incidents of misappropriation of property. (See attached policy/procedure and tracking tool.) Concurrent review will be conducted by the Chief Nursing Officer when incidents are reported. Any incidents will be reported quarterly to the Nursing Facility and Patient Safety Committees.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

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F 281	Continued From page 10 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services to meet professional standards of quality for two (2) of twelve (12) sampled residents (residents #3 and #4). Resident #1 had a physician's order for bilateral hand splints to be applied for two (2) hours and removed for two (2) hours; however, observations revealed the splints were not applied as directed by the physician's order. Resident #4 had a physician's order to be ambulated twice a day. There was no evidence the resident was being ambulated as ordered by the physician. The findings include: 1. Resident #3 was readmitted to the facility on September 25, 2009, with diagnoses to include Cerebrovascular Accident (CVA), Aphasia, Congestive Heart Failure (CHF), Diabetes Mellitus, and Hypertension. A review of the August 2010 physician's orders revealed resident #3 had orders for bilateral hand splints to be applied for two hours and to be off for two hours. A review of the occupational therapist's (OT) evaluation conducted on October 7, 2009, revealed resident #3 was assessed to have left side hemiplegia with increased tone in the left side and the right side was flaccid. OT services were provided for positioning, sensory stimulation, and staff/family education. Resident #3 was discharged from OT services on June 22, 2010, with education provided to Nursing Services to continue the application of bilateral	F 281	F281 The Chief Nursing Officer provided 1 on 1 instruction to the SRNA's of the need to document the application and removal of splints on Resident #3. The SRNA's were instructed to document this intervention on the Restorative Care Flowchart under the "Notes/Observation" section until such time as the Restorative Care Flowchart can be revised. The Chief Nursing Officer provided 1 on 1 instruction to the SRNA's of the need to document ambulation of Resident #4 per orders on the Restorative Care Flowchart. Emphasis was placed on the responsibility of the SRNA's to document the need for assistance, the distance ambulated, and the frequency of ambulation to be accomplished per the residents plan of care. The week of 9/20-9/24/10, the Facility DON reviewed the orders of current residents for treatments/procedures to ensure that orders had been acknowledged and were being carried out as ordered and to ensure documentation was being accomplished. Indicators were added to the Nursing Facility Documentation Audit Tool to assess for compliance with carrying out treatment orders. See attached Nursing Documentation Audit Tool. The Facility DON will assess for compliance and report findings monthly to the Chief Nursing Officer. The Chief Nursing Officer will report quarterly to the Nursing Facility Committee.	9/30/10

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F 281	Continued From page 11 hand splints to be on for two hours, off for two hours, and off all night. Resident #3 was observed on September 14, 2010, at 10:00 a.m., to be lying abed. No splints were observed to be in use. Resident #3 was not interviewable due to a diagnosis of aphasia. Additional observations conducted on September 14, 2010, at 12:50 p.m., 1:55 p.m., 2:35 p.m., 4:10 p.m., and 5:30 p.m., revealed the bilateral hand splints were in use during each observation. On September 15, 2010, resident #3 was observed at 9:15 a.m., 10:50 a.m., 12:30 p.m., and 2:00 p.m., and bilateral hand splints were observed to be in use during each observation. An interview conducted with the OT on September 16, 2010, at 2:50 p.m., revealed resident #3 had been discharged from OT services on June 22, 2010. The OT stated direction/education had been provided to the nursing staff to continue the application of bilateral hand splints for resident #3. The OT stated the splints were to continue to be on for two hours, removed for two hours, and off at night. An interview conducted with CNA #3 on September 15, 2010, at 2:05 p.m., revealed the CNA had removed the hand splints while providing the resident's bed bath after lunch on September 15, 2010. CNA #3 stated he/she was not sure whether the CNA was responsible for the application/removal of the hand splints for resident #3. CNA #3 stated the application/removal of the hand splints was not documented. CNA #1 stated in an interview conducted on	F 281	F 281 Continued Inservice education was provided to the Licensed Nurses and SRNA's on 9/21-9/30/10 on the documentation requirements and revisions to the Restorative Care Flowsheet and SNF Daily Flowchart. (See attached Inservice Attendance record and revised Nursing Facility Daily Flowchart.) A Performance Improvement Data Collection Tool was developed to monitor for compliance with documentation of restorative interventions on the Restorative Care Flowchart. 30 residents will be reviewed quarterly by the Nursing Facility DON. Results of findings will be reported quarterly to the Nursing Facility Committee by the DON. (See attached Performance Improvement Data Collection Tool and Calendar.)	

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F 281	Continued From page 12 September 15, 2010, at 2:10 p.m., that he/she was responsible to apply the hand splints during the day for resident #3 and the 3:00 p.m. to 11:00 p.m. shift was responsible to remove the hand splints. CNA #1 stated he/she was not familiar with a schedule to apply the hand splints for two hours and to remove the splints for two hours. A review of the policy/procedure regarding restorative nursing program (no date) revealed the therapist would provide education to the nursing staff regarding therapy services (splints, ambulation, incontinence management) when a resident was discharged from therapy services. The policy/procedure noted the nursing staff would be responsible for the provision of these services. An interview conducted with the DON on September 16, 2010, at 4:45 p.m., revealed the application of splints was to be provided by the CNAs and documented on the restorative nursing flowchart. The DON stated there was no documentation that the bilateral hand splints had been applied/removed as ordered by resident #3's physician. A review of the restorative nursing flowchart for September 14 and 15, 2010, revealed no documentation that the hand splints had been applied as ordered by the physician. 2. A review of the medical record for resident #4 revealed the resident had been admitted to the facility on April 8, 2010, with diagnoses that included Degenerative Joint Disease, Osteoporosis, Diabetes, Congestive Heart Failure, Malnutrition, Atrial Fibrillation, and Cerebrovascular Accident. Further review of the	F 281		

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F 281	Continued From page 13 medical record revealed a physician's order dated September 6, 2010, for staff to ambulate the resident two times daily; however, there was no evidence that the resident had been ambulated twice daily. Resident #4 was observed on September 14, 2010, at 8:15 a.m., 10:50 a.m., 12:07 p.m., 2:20 p.m., 4:30 p.m., and 5:30 p.m., and on September 15, 2010, at 9:00 a.m. and 1:45 p.m. There were no observations of resident #4 being assisted to ambulate. An interview with nurse aide #4 conducted on September 15, 2010, at 11:00 a.m., revealed nurse aide #4 was assigned to care for resident #4 and had not ambulated the resident. Nurse aide #4 stated he/she had not worked on this unit every day, but did ask the resident to let the nurse aide help her/him walk on Saturday, September 18, 2010, but the resident refused. Nurse aide #4 further stated he/she did not document the resident's refusal and did not notify the resident's nurse of the resident's refusal. An interview with the Director of Nursing (DON) conducted on September 16, 2010, at 2:45 p.m., revealed the DON had reviewed the resident's medical record and was unable to locate any documentation that the resident was being ambulated two times a day by staff.	F 281	F281 continued A Performance Improvement Data Collection Tool was developed to monitor for compliance with documentation of restorative interventions on the Restorative Care Flowcharts. 30 residents will be reviewed quarterly by the Nursing Facility Director of Nursing. Results of findings will be reported quarterly to the Nursing Facility Committee by the DON. (See attached Performance Improvement Data Collection Tool and Reporting Calendar.)	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide supervision and a safe environment to prevent accidents for four (4) of twelve (12) sampled residents (residents #6, #7, #4, and #9). The facility failed to assess/investigate the fall incidents to identify possible causal factors related to each fall and failed to implement individualized interventions to prevent further falls for these residents. In addition, the facility failed to monitor/evaluate the effectiveness of fall interventions to prevent additional falls for residents #6 and #3. The findings include: 1. A review of the medical record revealed resident #6 was admitted to the facility on January 5, 2005, with diagnoses to include Alzheimer's Disease, Psychosis, Dementia, Schizophrenia, and Hypertension. A review of the Significant Change Minimum Data Set (MDS) completed on September 17, 2009, revealed resident #6 was assessed to have short/long-term memory deficit with moderately impaired decision-making skills. Resident #6 was assessed to require extensive assistance for transfer, bed mobility, and toileting, and to have sustained falls in the past 30 days and in the past 31 to 180 days. In addition, resident #6 was assessed to have received psychotropic medications during the past seven days. A review of the Falls Resident Assessment Protocols (RAPs) dated September 17, 2009,	F 323	F323 Resident #6 was discussed at the Falls Committee Meeting on 9/24/10. The resident has incurred no further falls. There was discussion of causative factors of previous falls. Additional interventions to be implemented for resident #6 was purchasing hipsters to reduce the incidence of injury in the event the resident incurs another fall. The resident's Plan of Care was updated. (See attached plan of care for Resident #6) Resident #6 was discussed one on one with Nursing Staff on 9/17/10 in an effort to raise awareness of need to provide adequate supervision to resident, checking and documenting fall alarm status, and ensuring that call light and personal belongings are within resident's reach. The Interdisciplinary Care Planning Committee met on 9/22/10 to review all residents at risk for falls to ensure that care plans were up to date and included appropriate falls prevention interventions. The Falls Management Program Performance Improvement indicators were revised to include indicators to assess for completeness of Falls Incident Report/Risk Analysis form, identification of causative factors and effectiveness of interventions and follow up. 30 at risk residents and all residents that suffer a fall will be reviewed concurrently by the Facility DON. Results of findings will be reported monthly to the Chief Nursing Officer for quarterly reporting to the Nursing Facility and Patient Safety Committees. The Falls Incident Report/Risk Analysis will be reviewed every 2 weeks by the Falls Committee as well. The Chief Nursing Officer will continue to sign off on all Falls Incident Reports and will ensure completion of all areas of the form to expedite the review process when the Falls Committee meets to discuss the resident falls.	10/8/10

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F 323	Continued From page 15 revealed resident #3 had a history of falls and was on the falls program with interventions for a bed alarm, a non-skid mat beside the bed, to maintain the bed in low position, wheelchair alarm, and wheelchair brakes. A review of the incident report dated June 8, 2010, at 2:30 p.m., revealed resident #6's roommate reported resident #6 stood up at the side of the bed and fell to the floor, striking the resident's head on the lower bedrail. Further review of the incident/investigation report revealed there was no evidence the facility had evaluated the effectiveness of the bed alarm to alert staff when the resident self-transferred from the bed. A CT scan of resident #6's head revealed no injury was noted. The facility implemented a concave mattress; however, the mattress had to be ordered and was not implemented until July 1, 2010. On June 12, 2010, resident #6's roommate again reported the resident had climbed out at the foot of the bed and fell onto the floor. The resident was assessed to have no injury as a result of the fall. Again, the facility failed to evaluate the effectiveness of the bed alarm to prevent resident #6 from exiting the bed without staff awareness or assistance. On July 10, 2010, resident #6 was observed by facility staff to be standing by the wheelchair and leaning against a shredder machine in the employee break room. The resident was observed to become unsteady and to fall to the floor before staff could prevent the fall. No injuries were noted. There was no evidence the facility evaluated if the wheelchair alarm was in place and working when the resident sustained the fall. Resident #6 was moved closer to the nurses' station and no further falls had occurred.	F 323	F 323 Nursing Staff were instructed on the need to document the status of Resident #6 fall alarms on the Restorative Care Flowchart and the need to check the alarms every 2 hours. Inservice education has been provided on 9/21-9/30/10 to all staff on checking fall alarms and documenting on Restorative Care Flowchart. (See attached Inservice Attendance Records.)	

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F 323	Continued From page 16 A review of the facility's Falls Committee Meeting dated June 23, 2010, revealed resident #6's falls were reviewed, and the committee discussed the implementation of the concave mattress due to the resident's ability to remove the bed alarm. The minutes noted resident #6 removed the bed alarm and was able to be out of bed unassisted. However, there was no evidence the Falls Committee thoroughly investigated the possible causes for resident #6's falls and no evidence the Committee evaluated for the effectiveness of the bed/chair alarm to prevent further falls for the resident. Resident #6 was observed on September 14, 2010, at 9:55 a.m., 10:50 a.m., and 4:15 p.m., to be lying on a low bed with a concave mattress. In addition, an alarm mat was on the floor at the resident's bedside. At 5:15 p.m., resident #6 was observed to be in a wheelchair with a chair alarm in place with brake locks noted on the resident's wheelchair. On September 15, 2010, resident #6 was observed at 10:15 a.m., 12:30 p.m., and 2:00 p.m., to be in a wheelchair in the resident's room and/or hallway. A wheelchair alarm was observed to be in place and brakes were noted on the back of the resident's wheelchair. A review of the facility's policy/procedure regarding the Falls Management Program (dated January 2010) revealed residents identified to be at risk for falls would be placed on the Falls Precaution Program with appropriate preventative interventions implemented per protocol. The policy/procedure noted the incident report would be completed by the nurse and forwarded to the DON and Risk Manager for further review.	F 323		

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F 323	Continued From page 17 An interview conducted with LPN #1 on September 16, 2010, at 12:30 p.m., revealed the nurse was responsible to complete the incident/investigation report to assess the possible cause for the resident's fall. LPN #1 stated the investigation included evaluation of the current interventions (alarms) to determine if the device was in place and was working properly. An interview conducted with the DON and the MDS Coordinator (MDSC) on September 16, 2010, at 10:00 a.m., revealed the nurses were responsible to conduct the initial investigation when a resident sustained a fall. The DON and MDSC stated the nurse was responsible to obtain information to determine the causal factors related to the fall and to implement an immediate intervention to prevent further falls. The DON and MDSC stated the Falls Committee met every two weeks and reviewed each resident's falls and incident/investigation reports. The DON and MDSC stated the possible causal factors for resident #6's falls and the resident's ability to remove the bed/wheelchair alarms had not been evaluated to prevent further falls for the resident. 2. A review of the medical record revealed resident #7 was admitted to the facility on October 31, 2009, with diagnoses to include Dementia, Anemia, Alzheimer's Disease, and Degenerative Joint Disease. A review of the annual MDS assessment completed on February 12, 2010, revealed resident #7 was assessed to have short/long-term memory deficit with severely impaired decision-making skills. The resident was assessed to require total assistance of two staff persons for bed mobility, transfers, and toileting and to have sustained no falls during the assessment reference period. The resident was	F 323	F 323 Continued Resident #7 was discussed at the Falls Committee Meeting on 9/24/10. It was determined that the cause of the resident's fall was related to her ability to squirm and wiggle in bed resulting in her falling from the bed. There was a recommendation to obtain a body pillow or bolster to be placed on the side the resident is turned to keep her from making her way out of the bed. (See Plan of Care for Resident #7) Resident #7 care plan was reviewed and updated on 9/24/10, (See attached Plan of Care for resident #7.)	

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F 323	Continued From page 18 further assessed to be unable to sit or stand. A review of the comprehensive care plan revealed resident #7 was identified to be at risk for falls due to daily use of antidepressant medications and periods of delusions. Interventions included to keep the bed in a low position with brakes locked and to monitor the room with each passing by staff. Resident #7 was observed on September 16, 2010, at 9:55 a.m., 11:15 a.m., and 12:25 p.m., to be lying abed with pillows behind the resident's back and under the resident's knees. Resident #7 did not respond to verbalization. A review of the incident/investigation report dated August 28, 2010, at 8:50 p.m., revealed resident #7 was found lying on the resident's knees beside the resident's bed. The resident was assessed to have an abrasion to the right knee. A review of the "external risks" section of the investigation revealed the area to be incomplete and no information was provided related to potential causes for the resident's fall. An interview conducted with Registered Nurse (RN) #1 on September 16, 2010, at 2:25 p.m., revealed RN #1 was responsible for the completion of the investigation of resident #7's fall. RN #1 stated he/she discovered resident #7 lying on the floor when RN #1 had gone into the room to check on resident #7's roommate. RN #1 stated the RN was not sure how resident #7 had fallen to the floor since the resident was not able to move about in bed. RN #1 stated the RN did not conduct an investigation to attempt to determine how the resident had fallen from the bed to the floor.	F 323		

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F 323	Continued From page 19 An interview conducted with the DON on September 16, 2010, at 5:00 p.m., revealed the investigation into resident #7's fall had not been reviewed to determine the cause of the fall on August 28, 2010. The DON stated the investigation conducted was not thorough and had not been conducted according to facility protocol. 3. A review of the medical record for resident #4 revealed the resident was admitted to the facility on April 8, 2010, with diagnoses that included Degenerative Joint Disease, Osteoporosis, Atrial Fibrillation, Malnutrition, Diabetes, Congestive Heart Failure, and Cerebrovascular Accident. A review of a significant change Minimum Data Set (MDS) assessment completed by the facility on June 2, 2010, revealed the resident had sustained falls within the preceding 180 days. A review of the Resident Assessment Protocol (RAP) revealed resident #4 had a decline in Activities of Daily Living (ADL) function and cognitive status, and had episodes of confusion. The resident was further assessed to utilize anti-anxiety medications daily. A review of the comprehensive care plan for resident #4 revealed the resident had a history of falls due to weakness/confusion with the potential for self injury. Interventions to address the resident's risk for falls included: 1) Remind/encourage the resident to ask for or wait for assistance with transfer and/or ambulation; 2) Keep call light in reach at all times when in the room; 3) Upper side rails to assist with bed mobility; 4) Apply wander guard/alarm to clothing at night and remind the resident not to get up without assistance; 5) Monitor the resident with	F 323	F 323 Continued Resident #4 was discussed at the September 24, 2010 Falls Committee Meeting. Causative factors of this residents falls were reviewed and appropriate fall interventions were recommended to avoid falls while resident is attempting to transfer from bed/chair in room. A recommendation was also made to purchase hipsters for this resident to avoid injury if resident encounters any more falls. The residents care plan was updated to reflect interventions to be implemented.	

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F 323	Continued From page 20 each room passing for safety and comfort; 6) Assist the resident up to the bedside commode every two hours while awake; 7) Concave mattress; and 8) Reinforce resident to leave the wander alert on. Further review of resident #4's medical record revealed the resident had sustained seven falls from April 15, 2010 to September 16, 2010, while attempting to transfer unassisted. A review of the Falls Incident Reports/Risk Analyses (FIR) revealed the resident did not sustain injuries with any of the falls; however, according to the FIR, on April 15, 2010, June 6, 2010, June 29, 2010, July 25, 2010, August 25, 2010, August 27, 2010, and September 14, 2010, resident #4 sustained the falls while attempting to transfer without ringing for assistance. According to the FIR, the resident had removed the personal fall alarm for five of the seven falls. Interventions included: place on Falls Management Program, keep personal items within reach, re-apply personal alarm, reinforce compliance with waiting for assistance, increasing observation for 72 hours after the fall, and placing a fall mat at the bedside. A review of the Falls Management Program revealed all residents were to be assessed for risk for falls with appropriate precautions implemented upon admission and each shift. All residents identified as being at risk for falls were to be placed on the Falls Precautions Program. Each patient on the Falls Precautions Program or "Blue Dot" program was to have a blue dot placed on the resident's door and the overbed light, and to wear a blue armband. The blue armband and blue dots were to identify to staff the resident was at risk for falls. The nurse on duty was responsible to complete the Falls Incident	F 323	F 323 Continued A recommendation was made to keep a small padded chair at the sink for resident to sit in and help keep the resident from falling onto the floor. Resident uses the bedside commode and furniture to maneuver around in the room. Staff were instructed to offer toileting frequently as it was determined resident is usually trying to get to bathroom or up to bedside commode when she falls. (See attached plan of care of Resident #4.)	

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F 323	Continued From page 21 Report/Risk Analysis and forward a copy to the Director of Nursing (DON) and Risk Manager for review. An interview conducted with the Director of Nursing (DON) on September 15, 2010, at 2:30 p.m., revealed the facility had a falls committee that met monthly to discuss falls and attempt to prevent further falls and develop interventions to address resident falls. The DON was unable to locate committee minutes for July 2010 or August 2010. A review of the Falls Committee minutes revealed resident #4 was reviewed during the meeting held on June 9, 2010. There was no evidence the facility discussed causative factors or evaluated previous interventions for effectiveness for resident #4. The most recent Falls Committee meeting was conducted on June 23, 2010, with no discussion/evaluation of the interventions in place for resident #4. There was no evidence the Falls Committee had met since June 23, 2010, although resident #4 has sustained five falls since June 29, 2010. There was no evidence the facility assessed causal/risk factors for resident #4 and/or reviewed/revised the resident's care plan in an attempt to develop an individualized care plan to prevent falls. 4. A review of the medical record for resident #9 revealed the resident was admitted to the facility on August 8, 2006, with diagnoses that included Alzheimer's, Hypertension, Anemia, Chronic Obstructive Pulmonary Disease, and Degenerative Joint Disease. The Resident Assessment Protocol (RAP) completed on June	F 323	F 323 Continued The Falls Committee had not met in July but had met on August 25, 2010. Minutes were available but this resident had not been reviewed. Resident' # 4's Care Plan was updated on 9/24/10. Resident #9 has incurred no further falls. Fall interventions have been effective. The resident's plan of care was reviewed on 9/24/10 by Interdisciplinary Care Planning Committee. (See attached Care Plan for Resident #9.)	

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F 323	Continued From page 22 10, 2010, revealed resident #9 was at risk for falls due to psychoactive medication use, incontinence of bladder and bowel, periods of confusion, and Alzheimer's disease. According to the RAPs the resident would be continued on the falls program. A review of the FIR revealed on June 19, 2010, at 7:50 p.m., resident #9 was found on the floor beside the bed. The FIR listed causative factors as antidepressants, antihypertensives, diuretics, and dementia. The FIR revealed the resident had no history of previous falls. The immediate care measures implemented were increased observation of the resident for 72 hours after the fall and application of a fall alarm. A review of the Falls Committee minutes revealed resident #9 was discussed in the meeting, however, there was no evidence that specific causative factors were identified or discussed. An interview with the DON conducted on September 16, 2010, at 2:00 p.m., revealed the resident was discussed at the Falls Committee meeting; however, no investigation was conducted into the causative factors of the fall. The DON stated, "I don't know why she fell."	F 323	F 323 Continued Inservice education has been provided 9/22-10/3/10 to all staff on the falls prevention program, accident prevention, adequate supervision of residents, use of assistive devices, identification of causes of falls, and appropriate interventions to be implemented. (See attached Inservice Attendance Record.) The Fall Incident Report/Risk Analysis has been revised to include a more in depth analysis of the causative factors when a resident encounters a fall. The fall risk analysis has also been revised to include more interventions to be employed at time of a resident fall as well. (See attached Nursing Facility Fall Incident Report/Risk Analysis.)	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334	Inservice education was provided on 9/29-10/8/10 to the Nursing Facility Staff by the Chief Nursing Officer on revisions to the Fall Incident Report/Risk Analysis to be completed whenever a resident falls.	

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F 334	Continued From page 23 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F 334		

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F 334	Continued From page 24 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure education regarding the benefits and potential side effects for the pneumococcal vaccine was provided for one (1) of the eleven (11) sampled residents/legal representatives. The findings include: A review of the medical record for resident #5 revealed the resident was admitted to the facility on June 29, 2010. A review of the resident assessment and immunization administration record conducted on September 15, 2010, revealed the pneumococcal vaccine was not administered to resident #5. According to documentation on the immunization administration record, the resident's legal representative had been mailed a copy of consent for Pneumococcus Vaccination. Further review of the consent form revealed the consent did not	F 334	F 334 Education was provided to Resident #5 daughter including risks and benefits related to receiving/not receiving Pneumococcal Vaccine. The revised consent was utilized to obtain the resident's declination of the Pneumococcal Vaccine. (See attached Pneumococcal Vaccine Consent/Declination Form.) The Pneumococcal Vaccine consent form was revised to include the resident's signature/legal representative signature for refusal of the vaccine. The form was also revised to include the benefits of the vaccine and negative outcomes as a result of receiving the vaccine. (See attached Pneumococcal Vaccine Accept/Decline Form.) A review of current residents immunization status and records was conducted by the Nursing Facility DON and MDS Coordinator on 10/4/10 to determine if there were any other residents that had refused pneumococcal vaccine that needed education on the risks/benefits related to receiving/not receiving the vaccine. There were no other residents who had refused the vaccine. As of 10/8/10 there has been 1 newly admitted resident to refuse pneumococcal vaccine and appropriate education and written declination have been obtained.	10/8/10

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F 334	Continued From page 25 contain the resident's legal representative's signature to request the vaccine. The form had a written statement on the upper right hand corner, "refused family." However, there was no evidence resident #5's legal representative had received this form or information/education was provided to resident #5's representative. A review of the facility's policy/procedure related to the pneumococcal/influenza immunization program dated January 2010 revealed the policy/procedure did not address educating the resident or the resident's legal guardian regarding the benefits and potential side effects of pneumococcal immunization. An interview conducted with the Registered Nurse Supervisor on September 15, 2010, at 9:25 a.m., revealed the facility policy did not contain any information regarding the risk of declining the vaccine. The Supervisor stated the facility did not have a current system in place to ensure the resident's responsible representative received the mailed consent. The Supervisor stated the facility did not educate the residents or their responsible representative regarding the risk of refusal of the pneumococcal vaccine.	F 334	F 334 Continued The Policy on PPD Skin Testing, Influenza, and Pneumococcal Vaccine Records was revised to reflect the need to document the resident's acceptance or refusal of the vaccine, the information to be provided via the Vaccine Information Statement related to benefits and potential side effects of the vaccine, and the need to send the consent and information via certified mail return receipt requested to ensure receipt by the resident's legal representative. All staff were inserviced on the policy revisions. (See attached Inservice Attendance Record and policy.) Inservice education was provided on 10/6/10 to the Nursing Facility Licensed Nurses on obtaining the Pneumococcal Vaccine Consent/Declination and the policy for vaccination within 24 hours of resident admission. (See attached Inservice Attendance Record.) The Nursing Documentation Audit Tool was revised to include indicators to asses for compliance with documentation of a resident's acceptance or refusal of Pneumococcal Vaccine and notification of physician if resident refuses. Monitoring will be accomplished by the Nursing Facility DON for all residents monthly. Results of findings will be forwarded to the Infection Control and Nursing Facility Committee quarterly.	
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 354	F 354 A Full Time RN has been added to the Nursing Facility Schedule to service as the Director of the Nursing Facility. This nurse will be assigned to work 5 - 8 hour shifts per week for a total of a 40 hour work week. This nurse will assist the Licensed Nurses with resident care as needed and will assist the MDS Coordinator 5 hours per week.	10/8/10

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F 354	Continued From page 26 The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to designate a registered nurse to serve as the Director of Nursing on a full-time basis. The findings include: An interview conducted with the Director of Nursing (DON) on September 14, 2010, at 1:50 p.m., revealed the DON divided his/her daily working hours between the acute care hospital side of the building and the long-term care unit. The DON stated he/she was unaware of the regulation requiring a full-time DON. According to the regulation, full-time is defined as at least 35 hours a week. The DON further stated, "Historically, we have not done that; I do not spend 35 hours a week here on the long-term care unit." An interview with the Unit Supervisor (US) conducted on September 14, 2010, at 1:50 p.m., revealed the US divided his/her time between the acute side of the building and the long-term care unit. The US stated that she spent "a little less" than half of her/his working hours on the long-term care unit as supervisor. A review of the Facility Staffing revealed the RN Director of Nursing devoted eight hours in the previous two-week period to supervision of the	F 354	F 354 Continued The Chief Nursing Officer of the facility will monitor the daily and weekly staff schedules to ensure that the requirements are being met. Any variances noted will be reported to the Chief Executive Officer (CEO). (See attached daily schedules.)	

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F 354	Continued From page 27 Long-Term Care Unit.	F 354		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to serve palatable foods at appropriate temperatures for residents in the facility during the lunch meal on September 14, 2010. The findings include: Observation of the lunch meal on September 14, 2010, revealed a food cart was brought to the resident's floor by the dietary staff at 11:55 a.m. Further observation revealed the lunch meal trays from the food cart were taken into residents' rooms and placed on their overbed table by dietary staff. Observation revealed after each tray was passed by the dietary staff nurse aides entered each room and assisted the residents with setting up each meal tray. Observation revealed several trays were left on the food cart by the dietary staff. After assisting residents who could feed themselves, the nurse aides took a tray off the food cart and into one of the resident rooms who required total feeding. A facility staff person removed the last tray from the cart at 12:22 p.m. Two surveyors intercepted the food tray to conduct a palatability test with the	F 364	F 364 Temperature of Food A 2 cart delivery system was instituted, during survey on 9/14/10, at the time of distribution of dinner trays to the residents. The residents that have to be fed receive their tray on second cart pass. All other residents receive their tray on first cart pass. This allows time for the staff to get trays distributed and set up before time to feed the residents that cannot feed themselves so that food is maintained at acceptable temperature. The Dietician and Dietary Department Manager will monitor tray delivery and distribution and will check temperatures of food at random. Temperature of food is assessed before each meal on the tray line daily. A log will be kept by the Dietary Department Manager detailing the type of food, the temperature of the food, and the location whether it be tray line, point of delivery of tray, etc. of temperature checks. Food temperatures will be checked at point of delivery to residents in the Nursing Facility three times per week. Results will be reported to the Pharmacy and Therapeutics/Medical Records, and Dietary Committee quarterly by the Dietician. (See attached samples Dietary Department log for temperature and palatability testing of resident food trays.)	10/8/10

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F 364	Continued From page 28 participation of LPN #1. The meal was observed to be pureed. The temperature of the chicken with cream sauce was 102 degrees Fahrenheit, potatoes were 98 degrees Fahrenheit, peas were 96 degrees Fahrenheit, dairy honey-thick milk was 60 degrees Fahrenheit, and the chocolate pudding was 62 degrees Fahrenheit. An interview conducted with LPN #1 revealed the food tasted bland and was barely warm in temperature. LPN #1 stated dietary staff passed the trays to every resident that could feed themselves. LPN #1 stated the nurse aides then set up the trays. LPN #1 stated Dietary does not pass trays for the residents required to be fed. LPN #1 stated he/she was not aware of a certain timeframe required to get the trays passed to the residents. An interview with the Dietary Manager (DM) and the Dietitian conducted on September 14, 2010, at 1:57 p.m., revealed the DM and Dietitian stated food temperatures from the floor food cart meal trays had been monitored. The DM and Dietitian stated five test trays for various meals and at various points of service during the food tray passes were tested. The DM and Dietitian stated they had not conducted test trays at the point of service to the residents to ensure the food temperatures were acceptable.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store, prepare, and distribute foods under sanitary conditions. The findings include: 1. During the initial kitchen tour conducted on September 14, 2010, at 8:15 a.m., observation revealed the Dietary Production Manager to have facial hair that was unrestrained/uncovered and had the potential to contaminate food contact surfaces, foods, and dishware. An interview was conducted on September 14, 2010, at 8:15 a.m., with the Dietary Manager. The Dietary Manager revealed knowledge regarding the importance of wearing a protective covering on the head and beard but was unaware a mustache covering was required for male employees having facial hair in a food production/distribution area. 2. Initial observations of the Dietary Department on September 14, 2010, at 8:15 a.m., revealed the following: One Yoplait yogurt with an expiration date of August 29, 2010; One opened pecan pie with one slice missing, dated June 20, 2010, with freezer burn noted; One opened apple pie, with no date, and freezer burn noted;	F 371	F 371 The employee was instructed to cover facial hair with hair restraint by the Dietary Manager on 9/14/10. Yogurt, pecan pie, and apple pie were discarded on 9/14/10.	

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F 371	Continued From page 30 One partial lemon meringue pie, dated September 4, 2010, with freezer burn noted; One partial bag of burritos in clear plastic bag, with no date, and freezer burn noted; Corn beef observed in stainless steel container covered with plastic wrap, dated August 18, 2010, with freezer burn noted. Observation of the kitchen conducted on September 16, 2010, at 10:00 a.m., revealed the following: a tray line cooler with a large amount of condensation on both sides. Rust was observed the on mini-ramp entering the tray line cooler. The ice cream freezer was observed to have approximately three-fourths to one inch of condensation and ice buildup. The freezer contained retail items such as chicken tenders, French fries, and hash browns that were observed to have a buildup of condensation and ice. Two large garbage cans had grease and dirt buildup with cracks in the top of the cans and were in need of replacement. The top of the vegetable side oven had a moderate amount of rust and grease buildup. There was a large amount grease and food particles on the side of the stove next to the oven. The utility room had a mop and duster type scrubber that were soiled and on the floor of the dump drain. Interview with the Dietary Manager (DM) on September 14, 2010, at 8:15 a.m., and on September 16, 2010, at 10:00 a.m., revealed there should be no items in the refrigerator or freezers outdated or with freezer burn. The DM stated the dietary staff had a schedule to clean the kitchen and the previously mentioned soiled and dirty items must have been overlooked. The DM stated that condensation buildup could cause a freezing and thawing process which could affect	F 371	F 371 Continued Lemon meringue pie immediately discarded on 9/14/10. Burritos and Corned Beef were immediately discarded on 9/14/10. On 9/20/10 the cooler was defrosted per Dietary employee. The rust was removed from the cooler ramp. Ice cream freezer was defrosted on 9/20/10. Retail food items present in freezer at time of survey were discarded. The two large trash cans were discarded and replaced with new ones with lids on 10/6/10. Rust and grease buildup and the entire stove was cleaned on 9/2010. The mop and duster were removed from the floor in the utility room on 9/16/10. The Dietary Department Manager met with the Housekeeping Manager on 9/16/10 about dumpster lids/tops. A replacement lid has been ordered for the dumpster. The dumpster lid was replaced by the Poff Waste service on 9/24/10. The Dietary Department Manager met with and conducted education for the Dietary Department staff on all areas of noncompliance on 10/6/10. See attached attendance sheet and content of education provided. All areas of noncompliance were added to the Monthly Food Safety Audit. The DM will ensure checking of all areas. Results of findings will be reported quarterly to the Pharmacy and Therapeutics, Medical Records and Dietary Committee as well as the Nursing Facility Committee quarterly by the Dietician.	10/6/10

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F 371	Continued From page 31 the taste and quality of the product.	F 371		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage properly. Observation of the dumpster on September 16, 2010, at 10:00 a.m., revealed the lids were not closed and lids were missing. The findings include: A kitchen tour conducted on September 16, 2010, at 10:00 a.m., revealed the facility dumpster was missing two lids and the other four lids were not closed. An interview with the Dietary Manager conducted at 10:00 a.m. on September 16, 2010, revealed the dumpster lids should be in place and closed at all time due to pest and animal control issues.	F 372	F 372 The Dietary Department and Housekeeping Department Manager met to address the problems with the dumpster lids. Replacement lids were ordered and were put into place by Poff Waste Service. On 10/6/10, the Dietary Department Manager conducted a meeting and provided education related to the need to keep dumpster lids closed with the Dietary Department employees. See attached attendance record and content of education provided. The checking of the dumpsters was added to the Food Safety Audit to be checked monthly by the Dietary Department. Results of findings will be reported quarterly to the Pharmacy and Therapeutics, Medical Records and Dietary Committee and the Nursing Facility Committee by the Dietician.	10/6/10
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 32 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy/procedure, the facility failed to label all drugs and biologicals used in the facility in accordance with currently accepted professional principles including the expiration date when applicable. Resident #5 was observed to have tube feeding with water flush with no labeling regarding the resident's name, rate of administration, and time of administration. In addition, a vial of Tuberculin PPD vaccine was in the medication room refrigerator with no label as to the date opened.	F 431	F 431 Vial of PPD was discarded by LPN #1 on 9/16/10 at time of discovery of unlabeled vial. Resident #5 tube feeding label was filled out. Spot checks of tube feeding container have been conducted by the Chief Nursing Officer and Licensed Nurses daily since 9/20/10 and the resident's tube feeding has been labeled consistently. The Enteral Feeding policy/procedure was revised to reflect all elements of labeling requirements.	10/12/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	185182	A. BUILDING _____ B. WING _____	09/16/2010

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F 431	Continued From page 33 The findings include: 1. Observations in the medication room on September 16, 2010, at 2:30 p.m., revealed an opened vial of Tuberculin PPD with no label as to the date the vial was opened. An interview with Licensed Practical Nurse (LPN) #1 conducted on September 16, 2010, at 2:30 p.m., revealed the facility policy was that the nurse who first opened a vial for use was responsible for labeling the vial with the date opened. LPN #1 was unaware who had opened the vial. 2. Observation of resident #5 on September 14, 2010, at 10:00 a.m., revealed Jevity 1.5 Cal and a bag that contained water was observed infusing via a G-tube pump. Observation revealed the Jevity 1.5 and water had a label to document the resident's name, room number, date, start time, and infusion rate on these products. However, the label was observed to be blank. On September 14, 2010, at 3:48 p.m., the surveyor and LPN #1 entered resident #5's room. The surveyor revealed during the observation that since 10:00 a.m., resident #5's Jevity 1.5 Cal and water were observed to not be labeled with any information and 600 cubic centimeters (cc) of Jevity 1.5 and water had infused. Interview with LPN #1 on September 14, 2010, at 3:48 p.m., revealed the Jevity and water should have been labeled with the resident's name, room number, date, start time, infusion rate, and the initials of the nurse who prepared the solution. LPN #1 further stated without the information on	F 431	F 431 Continued Inservice Education was presented to the Licensed Nurses in the Nursing Facility from 9/24-10/08/10 on revisions to the Enteral Feeding policy and requirements for labeling (See attached Inservice Attendance Record and Enteral Feedings policy/procedure.) A Performance Improvement monitor has been developed to assess for compliance with labeling of tube feedings per policy. Data will be collected monthly on all residents receiving tube feedings by the DON. Results of findings will be reported quarterly to the Nursing Facility Committee Meeting by the facility DON. In addition to the monthly inspection conducted by Pharmacy to assess for compliance with all vials containing a date opened sticker, the Nursing Facility DON will conduct a weekly check on the unit to ensure compliance with labeling requirements. A Performance Improvement indicator to monitor for compliance was already in place from previous survey. Results of findings will be reported monthly to the Chief Nursing Officer by the facility DON. The CNO will report findings and action to the Nursing Facility Committee on a quarterly basis. Results will also be reported to the Pharmacy and Therapeutics Committee quarterly. (See attached Performance Improvement data collection tool and reporting calendar.)	

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F 431	Continued From page 34 the bags, no one would be able to know how long the Jevity and water had been hanging. A review of the facility's policy with a development date of September 2009 related to drugs and biologicals revealed the nurse was responsible for labeling the compounded product. Labels should indicate the patient's name and location, the name of the base parental solution, date prepared, name and amount of product, the name of or identifying code of the individual who prepared the solution, and supplemental instructions.	F 431	F 431 Continued Pharmacy will continue to perform monthly inspections of the Nursing Facility and assess for compliance with labeling of vials with the date opened stickers. The Chief Nursing Office will be provided with results monthly. Inservice education was presented to the Licensed nurses on the medication management policy/procedure for affixing date opened stickers with data and initials on vials at the time of initial entry. (See attached Inservice Attendance record and Drug Expiration policy dating requirements.)	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F 441 The Ice Cart was emptied and drained and was cleaned thoroughly by the Central Supply Department Employees. The Infection Control Preventionist provided inservice education to all staff responsible for ice passing on the need to keep the ice scoop in it's holder on each ice cart and to never leave the scoop in the ice inside the ice cart (See attached Inservice Attendance Record) The Infection Control and Prevention monitoring tool was revised to include an indicator to assess for compliance with keeping the ice scoop in its holder on the ice cart. (See attached Infection Control and Prevention Monitoring Tool.) Data collection will be accomplished by different Department Managers and Nursing Supervisors weekly. Results of findings will be forwarded to the Infection Control Preventionist monthly for quarterly reporting at the Infection Control and Nursing Facility Committee Meetings.	9/20/10

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F 441	Continued From page 35 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain an infection control program and proper infection control practices when two (2) nurse aides passed ice to residents on September 14, 2010 and September 15, 2010. The nurse aides stored the ice scoop in the ice cooler after filling each resident's ice pitcher. The findings include: Observations on September 14, 2010, at 4:30 p.m., revealed a nurse aide passing ice to residents. The nurse aide was observed to enter resident rooms and return to the hallway where the ice cooler was located with the resident's drinking cup/pitcher and fill the resident's drinking cup/pitcher with ice from the cooler. Each time the nurse aide filled a resident cup/pitcher the aide placed the scoop back into the ice cooler and closed the lid. An interview conducted with nurse aide #2 during the ice pass revealed nurse aide #2 was unaware the scoop was not to be placed back in the ice cooler. The aide stated the	F 441		

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F 441	Continued From page 36 staff does not have anywhere to store the ice scoop except the cooler. Additional observation on September 15, 2010, at 11:30 a.m., revealed nurse aide #1 passing ice to residents and placing the scoop back into the ice cooler between residents. An interview with nurse aide #1 during the ice pass revealed the aide was aware the scoop was not to be placed in the ice cooler, but there was no holder for the large ice scoop on the cart. Interview with the Infection Control Nurse (ICN) conducted on September 15, 2010, at 2:10 p.m., revealed staff was in-serviced on passing ice during orientation, but the ICN was unable to recall any recent in-services regarding ice pass. The ICN stated, "I will add it to the skills checklist."	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, sanitary environment for the residents, staff, and the public. Medication carts and computer carts were observed to be soiled and in need of cleaning. The findings include: Observations of the facility from September	F 465	F 465 Nursing Facility Wheeled computer carts were cleaned by the Point of Care Contact. A schedule for cleaning of computers on all medication carts and mobile workstations was developed by the Point of Care Contact. All computers will be cleaned each month. (See attached Computer Cleaning Schedule Log.)	9/29/10

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F 465	Continued From page 37 14-16, 2010, revealed the following areas were in need of housekeeping/maintenance services: 1. The wheeled computer carts were observed to be dusty, soiled, and in need of cleaning. 2. The medication carts were observed to be soiled inside and out and to have residue under the nameplates of the drawers. An interview conducted with Licensed Practical Nurse (LPN) #4 on September 16, 2010, at 2:30 p.m., revealed LPN #4 was responsible to ensure the computer carts were cleaned regularly. LPN #4 stated the carts were scheduled to be cleaned once monthly. An interview with LPN #1 conducted on September 16, 2010, at 2:40 p.m., revealed the outside of the medication carts was cleaned by the housekeeping staff and the inside was cleaned by Nursing when they had time. An interview with the Director of Nursing (DON) conducted on September 16, 2010, at 3:00 p.m., revealed that nurses were required to clean the medication carts monthly. The DON stated there was no documented schedule for cleaning the carts.	F 465	F 465 A medication cart cleaning log was developed by the Infection Control Preventionist to ensure that all medication carts are cleaned according to schedule per policy monthly. The day of the month for cleaning of the carts will be noted by a star placed next to the day and date. The cleaning logs will be picked up monthly by the Nursing Facility DON and forwarded to the Infection Control Preventionist. Results of cleaning logs will be reported at the Infection Control and Nursing Facility meetings quarterly by the Infection Control Preventionist. (See attached Medication Cart Cleaning Log.) The Quality Control Checklist for the Nursing Facility has been changed and an indicator to assess the cleanliness of medication carts and computers has been added. The checklist will be completed monthly by Unit Supervisors and forwarded to the Infection Control Preventionist. (See attached Nursing Facility Quality Control Checklist, also see attached Performance Improvement monitor for Medication Cart Cleaning Checks. 10 checks will be accomplished monthly via direct observation of carts and via review of the medication cart cleaning log. The Infection Control Preventionist will report findings quarterly to the Infection Control and Nursing Facility Committee.)	
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 468	On 9/21/10, the Infection Control Preventionist conducted inservice education for the Licensed Nurses on the Medication Cart Cleaning Log, the procedure for cleaning the carts, and the checking of carts for cleanliness each shift.(See attached Inservice Attendance Record, Medication Cart Cleaning Log, Policy/Procedure for Cleaning and Maintainence of Medication Carts, and Quality Control Checklist).	

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F 468	Continued From page 38 failed to equip corridors with firmly secured handrails. On September 16, 2010, the handrails between rooms 107 and 109 and next to room 115 were observed to be loose and not firmly attached to the wall. The findings include: Observations during a facility tour with the Maintenance Supervisor on September 16, 2010, at 2:50 p.m., revealed the handrails between rooms 107 and 109 and next to room 115 were loose and not firmly attached to the wall. An interview with the Maintenance Supervisor conducted on September 16, 2010, at 3:00 p.m., revealed the handrails were to be checked monthly, and was not aware the handrails were loose.	F 468	F 468 A work order request was completed by the Maintenance Department for the loose handrail. On the last day of Survey, September 16, 2010. New Anchors to refasten the handrail to the wall were installed on September 17, 2010. (See attached work order #112385.) On 9/17/10, the Maintainence Department Director conducted a walk thru in the Nursing Facility to check all handrails to ensure there were no other loose rails. All other handrails were secure and no additional work orders were needed. Handrails had previously been checked by the Maintenance Department on 8/10/10. Handrails were on a quarterly preventative maintenance schedule. As a result of this loose handrail, the Maintenance Department Director has changed the frequency of checking handrails from quarterly to monthly. (See attached work order # 112726 for handrail check for October 11, 2010. Also see attached Detail Report for hand Rails #16008009 indicating next monthly check on November 11, 2010.) Preventative maintenance reports will continue to be reported bi-monthly to the Safety Committee and quarterly to the Nursing Facility Committee by the Maintenance Department Director.	9/29/10
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 514		

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F 514	Continued From page 39 review, the facility failed to maintain accurate clinical records according to accepted professional standards for one (1) of eleven (11) sampled residents (resident #4). A review of the physician's orders for resident #4 revealed orders that had been discontinued were still listed as current. The findings include: 1. A review of the medical record for resident #4 revealed current physician's orders included "Lactated Ringers 1,000 milliliters (ml), 50 ml/hr, Sodium Chloride 0.9 %, 75 ml/hr, Oxygen at 28%, and Problem Clear Liquids." Further review revealed these orders were "September Reorder, continue (60) days unless otherwise ordered by the physician." Observations of resident #4 on September 14, 2010, at 12:07 p.m., revealed the resident was utilizing oxygen via nasal cannula at two liters/minute and eating a regular diet for lunch. No intravenous fluids were being administered. Further observation at 4:30 p.m. on September 14, 2010, revealed the resident was eating a sandwich and not utilizing oxygen at this time. Further observation of resident #4 on September 14, 2010, at 8:15 a.m., 10:50 a.m., 12:07 p.m., 2:20 p.m., 4:30 p.m., and 5:30 p.m., and on September 15, 2010, at 9:00 a.m. and 1:45 p.m., revealed intravenous fluids were not being administered during any of these observations. An interview with Licensed Practical Nurse (LPN) #3 conducted on September 15, 2010, at 10:50 a.m., revealed the facility procedure was for two licensed nurses to check the current month's preprinted orders with the previous month to	F 514	F 514 Clarification order obtained for Resident #4 IV fluids and oxygen. (See attached order dated 9/15/10.) Resident already had diet order for Regular Diet, clear liquids had bee ordered as pre-procedure prep only, but had not been d/ced from nursing orders report. All Licensed Nurses in the Nursing Facility were inserviced on the policy/procedure for transcription of orders. The policy for checking all orders on a monthly basis and for a double check procedure of all orders was emphasized. (See attached Inservice Attendance Record.) A Performance Improvement indicator has been developed to assess for accuracy of all physician orders on a monthly basis. The Nursing Facility DON will check all orders on each resident monthly to ensure that there is no duplication or errors with the orders. Direct observations will be conducted 10 times per month/30 per quarter for licensed nurses compliance with double check procedure for transcription of orders. Results of findings will be reported monthly to the Chief Nursing Officer for quarterly reporting to the Nursing Facility Committee. (See attached Performance Improvement Data Collection Tool and Reporting Calendar.)	10/12/10

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F 514	Continued From page 40 ensure accuracy. LPN #3 stated he/she had checked the current orders, however, he/she was so busy that he/she "just missed it." An interview was conducted on September 15, 2010, at 11:30 a.m., with LPN #2, who verified the current orders and stated, "I guess I was just too busy." LPN #2 stated resident #4 had received intravenous fluids recently. The LPN further stated one of the intravenous fluid orders and the clear liquid order was a one-day order in preparation for a diagnostic test. LPN #2 also stated the resident had oxygen ordered at 28% via mask when he/she was in the hospital and that since the resident had returned to the long-term care unit a nasal cannula at 2/liters per minute was used even though the order read "Oxygen at 28%." An interview with the Unit Supervisor (US) conducted on September 15, 2010, at 1:05 p.m., revealed the US did not monitor the staff to ensure accuracy when verifying orders. The US stated she/he had not been made aware the staff nurses were too busy to complete their tasks.	F 514		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		

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F 520	Continued From page 41 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have a Quality Assurance Committee which developed, implemented, and monitored plans of action to prevent accident/fall risks for residents identified to be at risk for falls/injuries. During the annual survey conducted on December 28-30, 2009, deficient practice was identified to exist related to accidents. The facility failed to ensure the plan of correction dated February 1, 2010, was effectively implemented and monitored to prevent reoccurrence of the previously cited deficiencies. In addition, the facility failed to monitor the implemented action plans to ensure ongoing compliance. This failure resulted in continued deficient practice related to accidents. (Refer to F323.) The findings include: An interview conducted on September 15, 2010,	F 520	F 520 The Fall Incident Report/Risk Analysis was revised 10/8/10 to include a better identification and analysis of causative factors. Inservice has been conducted for Nursing Facility Staff on completion of the Fall Incident Report/Risk Analysis Form. (See attached Fall Incident Report/Risk Analysis and Inservice Attendance Record.) The Falls Management Program Performance Improvement indicators already in place will continue to be monitored. Indicators have been added to ensure a follow up of interventions implemented, to evaluate effectiveness of interventions, and the need for implementation of new interventions. 30 at risk residents per quarter and all residents that suffer a fall will be monitored by the Nursing Facility Director of Nursing. Results of findings will be reported quarterly to the Chief Nursing Officer for quarterly reporting to the Nursing Facility and UR/Risk Management/Infection Control and Patient Safety Committee meetings. The Falls Committee will continue to meet every 2 weeks, at which time a more thorough investigation and analysis of causative factors and effectiveness of falls interventions will be accomplished. (See example of most recent Falls Committee Meeting Minutes of 9/24/10 as evidence of intense analysis of causative factors of resident falls and interventions to reduce the risk of resident injury.)	10/15/10

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F 520	Continued From page 42 at 3:25 p.m., with the DON revealed the Falls Committee consisted of the Unit Supervisor, MDS Coordinator, DON, Activity Director, Occupational Therapist, and a staff nurse from the 7:00 p.m. to 7:00 a.m. shift. The DON stated the committee met every two weeks to review each resident's falls and to evaluate the interventions implemented by the nurse who assessed the resident at the time of the fall. The DON further stated the Falls Committee was responsible to review the resident's care plan to determine if appropriate individualized interventions had been implemented based on the results of the fall investigation in an attempt to prevent further falls for the residents. A review of the facility's policy/procedure regarding the Falls Management Program (dated January 2010) revealed a Falls Incident Report/Risk Analysis would be completed by the nurse on duty at the time of the incident and that all areas of the report would be completed. The policy/procedure further directed that the Falls Incident Report/Risk Analysis would be forwarded to the DON and the Risk Manager to review. An interview conducted with the Quality Assurance (QA) Coordinator on September 16, 2010, at 4:30 p.m., revealed QA audits were conducted routinely by each Department Manager. The QA Coordinator stated the Unit Supervisor was responsible for conducting an audit of resident falls. The QA Coordinator explained that the review/audit consisted of a review of the completed falls investigation report to determine whether the investigation was thorough to assess the possible causal factors related to the resident's falls, and to determine the effectiveness of the resident's individual	F 520	F 520 Continued The UR/RM/IC and Patient Safety Committee will review the minutes of the Falls Committee on a quarterly basis and make a determination as to whether the committee is effectively identifying causative factors and implementing interventions that assist in the prevention of resident accidents and injuries. Any areas of concern will be addressed with the Facility Risk Manager to be addressed with the Falls Committee.	

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F 520	Continued From page 43 interventions to prevent further falls. The QA Coordinator stated after the previous survey the facility had formed a Falls Committee to review each resident's individual fall; however, the Falls Committee had not been effective in evaluating the completion of the Falls Incident Reports. In addition, the QA Coordinator stated the system had not been effective in reviewing the resident's falls. The QA Coordinator stated the most recent QA meeting had been conducted in August 2010; however, no further action plans had been implemented related to accidents/falls.	F 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185182	A. BUILDING _____ B. WING - MAIN BUILDING 01	09/14/2010

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on September 14, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The findings include: Deficient practice related to the facility's failure to conduct fire drills at least quarterly and/or under different staffing levels and conditions was cited during annual surveys on April 2008 and	K 050	K 050 Through a collaborative effort, PCH has developed a tool to assist in the recommendation for "unexpected times under varying conditions". This tool is to structure a variance of times for fire drills during a shift. Exhibit 1 illustrates the designed structure by assigning an exact time that each drill must be conducted, for example. 3rd shift is scheduled for a fire drill at 3:00 AM, 5:30 AM, 1:00 AM, 12:30 AM covering the majority of the shift. (See attached Program Schedule Fire/Safety Itinerary.) Compliance will be monitored by the Security Supervisor and will be reflective on an employee performance evaluations. The Security Supervisor will include this activity in his performance improvement report submitted to the Hospitals' PI Committee. This is reported quarterly.	10/17/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Breed	CEO	10/11/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 050	Continued From page 1 December 2009. According to the facility's latest plan of correction this deficient practice was corrected on January 21, 2010. The facility alleged fire drills would be conducted "per requirements on all shifts at varying times." However, there was no evidence the facility ensured fire drills were conducted as required. During the Life Safety Code survey on September 14, 2010, at 11:00 a.m., with the Director of Maintenance, a record review revealed the facility had not been performing fire drills at unexpected times and varying conditions on the first and third shift as follows: Two fire drills on the first shift from March 2010 to August 2010 were conducted between 11:29 a.m. and 11:50 a.m., with a required fire drill missing between March and August 2010. Three fire drills on the third shift from January 2010 to July 2010 were conducted between 1:55 a.m. and 3:00 a.m. An interview with the Director of Maintenance on September 14, 2010, at 11:00 a.m., revealed security personnel were responsible for conducting the fire drills.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on an interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected all of the facility's smoke compartments, staff, and all the residents. The findings include: During the Life Safety Code tour conducted on September 14, 2010, at 10:30 a.m., an interview with the Director of Maintenance revealed two fire alarm panels were located in the facility and both panels were needed to silence the fire alarm system when activated. The Director of Maintenance was unaware the fire alarm panels should function as a single system. Reference: NFPA 72 (1999 Edition). 3-8.1* Fire Alarm Control Units. Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as stand alone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance.	K 052	K 052 The Hospital has contacted its contractor, Simplex, a fire/life safety maintenance company, on September 30, 2010 for a RFP to link two fire panels together for purposes of silencing the system when activated. PCH anticipates this plan by October 22, 2010.	10/22/10
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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K 056 SS=D	Continued From page 3 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that an outside canopy was of noncombustible construction or sprinkler protected as required. The findings include: During the Life Safety Code survey on September 14, 2010, at 9:20 a.m., with the Director of Maintenance, a combustible canopy approximately 10 feet by 24 feet located at the back of the facility was observed not to be of noncombustible construction or sprinkler protected. Combustible canopies and overhangs exceeding four feet in width must be noncombustible or sprinkler protected. An interview with the Director of Maintenance on September 14, 2010, at 9:20 a.m., revealed that he/she was aware the canopy should be of	K 056	K 056 PCH Work Order #112785 has been approved for the replacement of material to be non-combustible construction. This project has been initiated and the project completion date is expected to be completed by October 16, 2010. (See work order #112785.)	10/16/10

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K 056	Continued From page 4 noncombustible construction or sprinkler protected. Reference: NFPA 13 (1999 Edition). 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, interview, and records review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected all of the facility's smoke compartments, staff, and all the residents. The findings include: The Life Safety Code tour on September 14, 2010, from 9:40 a.m. through 10:45 a.m., with the Director of Maintenance, revealed corrosion on battery terminals of the facility's four generator sets. Three of the generator batteries were	K 144		

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K 144	Continued From page 5 improperly wired to the battery chargers. An interview with the Director of Maintenance on September 14, 2010, at 10:00 p.m., revealed different maintenance personnel checked the generators weekly and the battery terminals should have been cleaned. The Director of Maintenance was unaware the battery charger was not connected correctly. In addition, a record review revealed routine maintenance checks, i.e., fluid levels, hoses, and belts, were not being recorded on the generator's weekly maintenance schedule. An interview with the Director of Maintenance on September 14, 2010, at 10:45 a.m., revealed these items were being checked but were not logged. Reference: NFPA 110 (1999 Edition). 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturer ' s recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals. 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established 6-3.6* Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full	K 144	K 144 Current deficiency has been corrected as of September 14, 2010 by cleaning the battery terminals of corrosion. In addition, PCH has revised its current PM check of generators to include a check and cleaning of battery terminals. (See Weekly PM work order.) As of September 14, 2010 the monthly check list was changed to a weekly PM for batteries to check for corrosion. The Monthly PM has been revised to include a check of fuel levels, hoses, and belts so that PCH will maintain a written record of checks. A work order (# 113131) was completed on 9/29/10 to rewire the battery charger. The hot wire from the charger was taken off of battery and ran to the starter.	9/14/10

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K 144	Continued From page 6 compliance with manufacturer ' s specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer ' s recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.7 The routine maintenance and operational testing program shall be overseen by a properly instructed individual.	K 144		